STATE OF MONTANA EMPLOYEE GROUP BENEFITS PLAN
2008 ENROLLMENT/CHANGE FORM

Please see back of this form for complete instructions, including information on Effective Dates, Declaration of Tax Status, and Qualifying Events.

Last Name	First Name	MI	Social Security #
Street or PO Box		Work #	SABHRS Employee ID#
City	State	Zip	Agency Name

☐ **WAIVER OF COVERAGE** – I have been given the opportunity to enroll in the State Employee Benefits Plan and decline participation at this time. I understand that if I decide to participate after my initial 31 day enrollment period, I may enroll myself only in the Core Plan, but my existing dependents can **only** be added to the Medical plan at the time they have a Qualifying Event – explained on the back of this form. *Skip to Part 5*

PART 1 – NEW ENROLLMENT/ Re-enrollment after Leave of Absence – Complete Parts 1, 3, 4 & 5
You must complete and return this form to your agency HR/Payroll personnel within 31 days of first day of employment/return.

1. Date Employed or Returning to Work: ___ / ___ / 08
2. Effective Date of Enrollment: ☐ 1st day of full pay period following receipt of form OR ☐ Date of hire – *I agree to self-pay if necessary*

3. Select Coverage

Check Coverage Elected	Medical	Dental	Vision
Myself only			
Myself & spouse			
Myself & child(ren)			
Myself & family			
Joint Core*			**N/A**

4. Select Pre-tax Plan *(available only to new enrollees or during annual change)*
☐ Deduct my premiums **before-tax** OR ☐ Deduct my premiums **after-tax**

5. Select Medical Plan
Indemnity Plan:
☐ Traditional
Managed Care Plans: *(check plan's service area in New Employee Booklet)*
☐ Peak
☐ New West
☐ Blue Choice

***Joint Core Partner's Name**_____ **SS#** _____ **Agency** _____

☐ I am currently a dependent on the State Plan under: Name _____ SS# _____ Agency _____

PART 2 – CHANGES TO DEPENDENT COVERAGE – Complete Parts 2, 3, 4 & 5
To add or delete dependents, be sure to indicate the qualifying event allowing the change AND the date of the qualifying event.

☐ **Add a Dependent:** *(qualifying event must have been within last 63 days with the exception of birth and adoption. If dependent has or had other coverage within the last 63 days, attach Certificate of Prior Coverage.)*
DATE OF EVENT _____
☐ **Marriage** *(attach copy of marriage certificate)* ☐ **Declaration of a Domestic Partner Relationship** *(attach Declaration of Domestic Partner form)*
☐ **Birth of child** *(attach copy of birth certificate)* ☐ **Adoption/Pre-adoptive placement**** *(attach copy of adoption/pre-adoption papers)*
****Effective Date of Enrollment for adoption: ☐ 1st day of full pay period following receipt of form OR
☐ Date of adoption– *I agree to self-pay if necessary*
☐ **Court-ordered custody/Support/Legal Guardianship** *(attach copy of court order)*
☐ **Dependent lost eligibility for other group medical coverage due to, specify:**_____ OR ☐ **there was a major adverse change in other coverage** *(attach documentation of change from dependent's plan/employer and Certificate of Prior Coverage.) The Date of Event you list above should be the last date of the other coverage or the change in coverage.*
☐ **Dependent transferring to you from another State Plan member** *(specify from whom)*
Name: _____ SS# _____ Agency: _____
☐ **Elect Joint Core due to Spouse's employment change or addition of a child**
Joint Core Partner's Name: _____ SS# _____ Agency: _____
☐ **Other - Not related to one of above events** – Specify reason: _____

☐ **Delete a Dependent:** (*Contact the Health Care and Benefits Division within 60 days for COBRA continuation information)
DATE OF EVENT (required) _____
☐ **Death of spouse/child**
☐ **Divorce*/Legal separation*/Change in support order*** *(attach copy of court order)*
☐ **Dissolution of Domestic Partnership*** *(attach Domestic Partner Dissolution Form)*
☐ **Other loss of Child's dependent status*** due to, specify:_____
☐ **Cancel Joint Core due to spouse's termination of employment, or deletion of last child**
Joint Core Partner's Name: _____ SS# _____ Agency: _____
☐ **Spouse/Child became eligible for other employer benefits** (*provide date of event above)*
☐ **Major change in other coverage** *(attach documentation of change from dependent's plan/employer.)*
☐ **Other - Not related to one of above events*** – Specify reason: _____

PART 3 – DEPENDENTS

Circle One	*Circle Coverages*	*Circle Relationship*	*Name*	*Birth Date*	*Social Security #*	*Tax Status Declaration* *See Part 4 & back of form*
Add / Delete	Medical/Dental/Vision	Spouse				☐ Qualified ☐ Non-Qualified
Add / Delete	Medical/Dental/Vision	Son/ Daughter				☐ Qualified ☐ Non-Qualified
Add / Delete	Medical/Dental/Vision	Son/ Daughter				☐ Qualified ☐ Non-Qualified
Add / Delete	Medical/Dental/Vision	Son/ Daughter				☐ Qualified ☐ Non-Qualified

PART 4 – DECLARATION OF TAX STATUS: My signature in Part 5 indicates that I have received the necessary Declaration of Tax Status flowcharts and have made the corresponding elections for each dependent listed above. I have read the Declaration of Tax Status instructions and information on the back side of this form and am aware of the implications of my choices therein. I understand that the State of Montana has a legitimate need to confirm whether my spouse, domestic partner and/or any covered children meet the appropriate definition(s) for tax purposes for the medical, dental and/or vision plans. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I agree to notify the Health Care and Benefits Division if there is any change in these circumstances within thirty (30) days of the change. I am aware that changes may impact the tax treatment of my coverage.

PART 5 – SIGNATURE / CERTIFICATION: I elect the coverage or changes indicated above. By signing below, I certify that: **1)** the above information is correct and my coverage elections are considered an irrevocable agreement for this benefit year; **2)** I agree to pay the premium necessary to effect this coverage and authorize payroll deduction, if applicable; **3)** I understand the 12-month waiting period on pre-existing conditions and know that if I had other coverage prior to State Plan enrollment, I need to provide a Certificate of Prior Coverage in order to receive credit toward the waiting period; and **4)** I understand I can only enroll dependents in my medical plan during my initial enrollment or with a Qualifying Event, as described on the back of this form.

Signature _____ **Date** _____

ADMINISTRATIVE USE ONLY
Effective Date _____
Assigned by _____
Agency # _____
Location _____

System Entry Date _____
Entered by _____

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INSTRUCTIONS

WAIVER OF COVERAGE – If waiving enrollment in the Employee Group Benefits Plan, please complete the Name/Address section and mark the Waiver of Coverage box, then sign and date the form in Part 5.

NEW ENROLLMENT/RE-ENROLLMENT – If enrolling for coverage, or re-enrolling following approved leave without pay, please: a) complete all applicable sections of Part 1, including the Pre-Tax section (not available to re-enrollees until next annual change period); b) mark the effective date of coverage you select, after reading the "EFFECTIVE DATE" section below; and c) list the names and other information, for all ***dependents**** to be insured, in Part 3.

- **Re-enrollees -** Employees will have a 12-month waiting period for coverage of any pre-existing medical conditions if coverage lapsed for more than 63 days before re-enrollment.
- The **Joint Core** provision gives employees, whose spouse also works for the State, medical & dental coverage for dependent child(ren) with only one family deductible, out-of-pocket maximum and may have a lower premium.

CHANGES TO DEPENDENT COVERAGE –To make dependent changes: a) check the ***Qualifying Event****** necessitating the change and provide the date of the event in Part 2; (also provide any indicated documentation such as a divorce decree or, for a major change in other coverage, documentation of benefits and premiums before and after the change); and b) list the names and other information for affected ***dependents**** in Part 3, if applicable.

*****Eligible Dependent*** is defined in the Employee Benefits Summary Plan Document. It is the responsibility of the employee to only enroll, re-enroll or add dependents that satisfy the definition of eligible dependent and to remove from coverage, any dependents that become ineligible as a result of divorce or some other change of circumstances. Contact your agency insurance personnel immediately when dependents become ineligible for coverage. *The employee will be held responsible for repayment of any claims dollars paid for an ineligible dependent which exceed premiums collected for the ineligible dependent. Also, any excess premiums paid for coverage of a dependent that cease to be eligible cannot be refunded if you are in the Pre-tax Plan.*

EFFECTIVE DATE – All effective dates are determined as follows:

Effective Date for New Enrollment/Re-enrollment:

- Enrollee may choose date of hire or first day of pay period following receipt of form. ***If neither option is chosen, the enrollee effective date will default to the first day of the pay period following receipt of the form.*** Form must be received at the Health Care and Benefits Division within 31 days of hire date. Some premiums may be paid on an after-tax basis if you elect date of hire.

Effective Date for Addition of Dependents:

- The first day of the pay period following receipt of form, with the exception of birth and adoption. Form must be received at the Health Care and Benefits Division within 63 days of qualifying event.
- *Birth and adaption, forms must be received within 63 days after the 31 days of automatic coverage (94 days from date of birth/adoption).*
    - **Birth:** the effective date is always the date of birth.
    - **Adoption:** with an adoption enrollee may choose an effective date of the first day of the full pay period following receipt of form. ***If neither option is chosen, the enrollee effective date will default to the first day of the pay period following receipt of the form.***

Effective Date for Deletion of Dependents:

- First day of the pay-period following the *Qualifying Event***
    - Divorce, legal separation, and Domestic Partner premiums will be taken through the end of the month in which event occurs.
    - Refunds will not be allowed for late notification.

****Qualifying Event* – For adding Dependents after an employee's *initial 31-day enrollment period*:**

- Events creating new dependent status – marriage, domestic partner declaration, birth of a child, adoption or pre-adoption placement, court-ordered custody, a medical child support order, legal guardianship.
- For existing dependents (who were not initially enrolled because of other group medical coverage), events causing loss of eligibility for the other coverage, such as termination of a spouse's employment, or a major adverse change in the other coverage. *Dependents can also be added to the dental and vision plans each Annual Change Period.*

****Qualifying Event* – For an employee on the Pre-Tax Plan to delete a dependent or dependents from coverage mid year:**

- Events causing loss of dependent status and therefore, eligibility for State employee benefits such as divorce, legal separation, dissolution of a domestic partner relationship, or death of a dependent. (all require documentation except the event of a death)
- A change in the employee's employment status (such as leave without pay).
- Changes in dependent's employment or legal status which make them eligible for other group insurance coverage (such as employment of a spouse, marriage of a dependent child, or a change in a child support decree, or a major change in the other insurance coverage, such as a new plan option.

DECLARATION OF TAX STATUS –

The State of Montana is required by the Internal Revenue Service to apply the proper tax treatment (before or after-tax) to benefits for every family member currently enrolled in medical, dental, or vision benefits. Therefore, it is important that you provide the tax status of each person enrolled. The qualification of these individuals as your spouse and/or dependent(s) for tax purposes does not affect their eligibility for the medical, dental or vision plans, but does impact the tax treatment of that coverage.

Flowcharts are provided to assist you in determining and verifying the tax status of your family members. The flowcharts provide the most complete overview of the tax rules possible; however, given the complexity of those rules, we recommend that you consult with your tax advisor regarding your specific circumstances.

For each dependent enrolled in medical, dental or vision benefits, check one of the two boxes next to each dependent's name in Part 3. If you do not indicate a the tax qualification status, premium contributions for those persons will be taken on an after-tax basis and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for these persons will be added to your taxable income. With respect to any person for whom you have checked "Non-qualified," premium contributions for those persons cannot be taken on a pre-tax basis and the fair market value of the benefits provided by the State of Montana (i.e., those benefits funded through the state share) for these persons will be added to your taxable income.